Health Claims for Auto Insurance

FACILITY WEB MANUAL

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CHAPTER 9: REASON CODES UTILIZED BY ADJUSTERS

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CHAPTER 9

Reason Codes Utilized by Adjusters

What Are Reason Codes?

When insurance adjusters make an adjudication decision, they must specify the reason behind the decision. The list of approval reason codes used in the HCAI application falls within five series:

- Adjuster Decision
- Adjuster Decision Update
- Pending
- Withdrawn
- Information

Each code consists of three groups of numbers:

1. The first number = series
2. The middle two numbers = category
3. The last two numbers = reason

Example

Code 1.00.05 means the following:

- Series 1 – Adjuster Decision
- Category 00 – Invalid Authorization
- Reason 05 – Authorization number error

Series 1 - Adjuster Decision

Code	Description
	Category 00 – Invalid Authorization
1.00.00	Authorization number required
1.00.05	Authorization number error
1.00.10	No record of authorization
	Category 01 – Authorization Required
1.01.00	Product/service requires prior authorization
	Category 02 – Authorization Exceeded
1.02.00	Authorized quantity exceeded
1.02.05	Authorized amount exceeded
1.02.10	Authorized unit cost exceeded
	Category 03 – Authorization Period
1.03.00	Prior to authorization eligible period
1.03.05	Authorized time period exceeded
	Category 04 – Pre-Approved Framework (PAF) and Other Bill 198 Changes
1.04.00	PAF Guideline exceeded

Code	Description
1.04.05	Good or service is not covered within the PAF Guideline
1.04.10	Good or service is not separately reimbursable within PAF
1.04.15	Transfer to another provider
1.04.20	Transfer to another PAF
1.04.25	Diagnosis indicates that PAF is appropriate
1.04.30	Diagnosis indicates that another PAF is appropriate
1.04.35	Assessment/examination limits exceeded
	Category 05 – Date of Service/Benefit Period
1.05.00	Date of service precedes date of loss
1.05.05	Time limit for filing has expired
1.05.10	Billing date precedes date of service
	Category 06 – Diagnosis of Patient
1.06.00	Diagnosis is inconsistent with the provider type
1.06.05	Procedure is inconsistent with the diagnosis
1.06.10	Diagnosis is inconsistent with the cause of loss
	Category 07 – Goods and Services
1.07.00	Not reasonable and necessary
1.07.05	Expenses incurred after settlement of claim
1.07.10	Procedure code is inconsistent with the provider type
1.07.15	Service/product is inconsistent with the cause of loss
	Category 08 – Duplicate Processing
1.08.00	Duplicate service/product by other provider
1.08.05	Duplicate service/product by same provider
	Category 09 – Fees
1.09.00	Fee exceeds reasonable fee for product or service
1.09.05	Fee exceeds maximum allowed
1.09.10	Service/procedure time adjustment
	Category 10 – Require Supporting Information
1.10.00	Supporting information insufficient/incomplete
	Category 11 – Policy Definition
1.11.00	Does not match claimant information
1.11.05	Policy/coverage identity error
1.11.10	Transportation deductible not exceeded
1.11.15	Policy coverage limits exceeded

Source: Health Claims for Auto Insurance Processing

Code	Description
1.11.20	Patient must claim reimbursement
1.11.25	Good or service not covered
	Category 12 – Financial Charges
1.12.00	GST is incorrect or not applicable
1.12.05	PST is incorrect or not applicable
1.12.10	Interest is incorrect or not applicable
	Category 13 – Coordination of Benefits
1.13.00	Collateral insurance missing or incorrect
	Category 14 – Conflict of Benefits
1.14.00	There is a conflict of interest
	Category 15 – Other
1.15.00	Claimant signature is required
1.15.10	No comment

Series 2 – Adjuster Decision Update

Code	Description
	Category 00 – Decision Update of Claim
2.00.00	Decision updated in accordance with a binding medical opinion
2.00.05	Decision updated in accordance with a binding arbitration or litigation ruling
2.00.10	Decision updated based on new information received
2.00.15	Decision updated because of conflict of interest
2.00.20	Decision updated based on agreement by all parties

Series 3 – Pending

Note: Insurers are required to respond to OCF-18s and -23s within the SABS timelines. The use of the Pending status does not eliminate the requirement for responses.

Code	Description
	Category 00 – Missing or Incomplete Information
3.00.00	Application for benefits missing or incomplete
3.00.05	Statement under oath not yet complete
3.00.10	PAF discharge and summary is missing or incomplete
3.00.15	Supporting documentation missing or incomplete
3.00.20	Claimant signature is required
3.00.25	Statutory declaration not received

Code	Description
	Category 01 – Coordination of Benefits
3.01.00	Collateral insurance information in error
3.01.05	Collateral insurance information missing
3.01.10	Patient has other coverage
3.01.15	Claimant is receiving WSIB benefits
	Category 02 – Policy Definition
3.02.00	Policy/coverage identity error
3.02.05	Does not match claimant information
	Category 03 – Medical/Legal/Mediation
3.03.00	Pending binding medical opinion
3.03.05	Pending arbitration or litigation ruling
3.03.10	Pending resolution of conflict of interest
3.03.15	Pending agreement by all parties

Series 4 – Withdrawn

Code	Description
	Category 00 – By Provider
4.00.00	Withdrawn on behalf of the provider
	Category 01 – By Claimant
4.01.00	Withdrawn on behalf of the claimant
	Category 02 – By Data Entry Centre
4.02.00	Withdrawn on behalf of the DEC
	Category 03 – By Insurer
4.03.00	Withdrawn on behalf of the insurer

Series 5 – Information

Code	Description
	Category 00 – Authorization Reached
5.00.00	Authorized quantity reached
5.00.05	Authorized time period reached
5.00.10	Authorized amount reached
	Category 01 – Approaching Coverage Limits
5.01.00	Approaching policy coverage limits